



TEXAS PAIN CENTERS
 800 BONAVENTURE WAY, SUITE 119
 SUGAR LAND, TX 77479
 PHONE: 832-730-7246
 FAX: 844-302-5696

Medical Records Request Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Some requests (e.g. personal copy / use) may be subject to a reasonable fee.

(A) Patient Information

Name: _____
 Date of birth (MM/DD/YYYY): _____
 Address: _____
 Phone: _____
 City: _____ State: _____ ZIP: _____

(B) What information are you requesting? (Mark all that apply)

Date(s) of service: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Clinic/ Outpatient Record
(includes history and physical exam, progress notes, operative and pathology reports, consultation reports, imaging & diagnostic studies reports) | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Past/Present Medications |
| | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Patient Allergies |
| | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Billing (Claim) Information |
| | <input type="checkbox"/> EKG/Cardiology Reports | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Lab Results | <input type="checkbox"/> All health information |

Mental/behavioral health records (may require physician/psychologist approval):

Psychiatric/mental health records Neuropsychological testing Other _____

(C) Purpose of Disclosure: (Please select only one box)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Insurance | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Treatment/Continuing Medical Care | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Disability Determination | |
| | <input type="checkbox"/> School | |

(D) To be completed only for third-party disclosures. (If the disclosure is for personal use, skip this section.)

I want the requested medical records to be sent to the third-party (e.g. health care provider etc.) I have indicated below. My completion of this form serves as authorization for Texas Pain Centers to disclose these records to this person or group. I understand that once my information leaves Texas Pain Centers, Texas Pain Centers is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name: _____ Phone: _____

Mailing Address: _____

(E) Terms of Authorization: I understand this authorization may be revoked in writing at any time, according to the instructions in Texas Pain Centers Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here: _____. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. **The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.**

Signature _____ Date: _____

Printed name: _____ Relationship to patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certaintypes of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Minor's Signature: _____ Date: _____

Mail or deliver completed form to:
Texas Pain Centers
 800 Bonaventure Way Suite 119, Sugar Land, TX 77479
 Fax: 844-302-5696 / E-mail: staff@texaspaincenters.org